IN THE CORONERS COURT
AT CHARTERS TOWERS
AND BRISBANE
IN THE STATE OF QUEENSLAND

IN THE MATTER OF AN INQUEST INTO
THE CAUSE AND CIRCUMSTANCES
OF DEATH OF ANDREW DAVID LATHER

On the 9th August 2006, an inquest was commenced in Charters Towers into the cause and circumstances of death of ANDREW DAVID LATHER. The inquest continued in Charters Towers on the 10th and 11th August 2006 and concluded here in Brisbane on 28th February and 1st March 2007.

My role is to proceed now, pursuant to s.45 (1) of the Coroner's Act 2003, to find, if possible, how Andrew died, when he died, where he died and what caused him to die.

It is important to state that "…. an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, and there is no trial, simply an attempt to establish facts".[1]

Although a coronial inquiry is not a judicial proceeding in the traditional sense, however, the rules of natural justice and procedural fairness are applicable, the content of such rules to be applied depending upon the particular facts of the case in question.

In formulating my findings, I am not permitted to include in my findings any statement that a person is, or may be –

(a) guilty of an offence; or
(b) civilly liable for something,[2] although I am permitted to comment on anything connected with a death investigated at an inquest that relates to-
(a) public health or safety; or
(b) the administration of justice; or
(c) ways to prevent deaths from happening in similar circumstances in the future.[3]

Similarly in making such comments, I must not include in the comments any statement that a person is, or may be –

(a) guilty of an offence; or
(b) civilly liable for something.

If, from information obtained while investigating a death, I reasonably suspect a person has committed an offence, I must, give information to –

[1] Per Toohey J in Annetts v. McCann 65 ALJR 167 at 175.
[2] S. 45(5) Coroners Act 2003.
[3] S. 46 Coroners Act 2003.

(a) for an indictable offence – the director of public prosecutions; or
(b) for any other offence – the chief executive of the department in which the legislation creating the offence is administered.[4]

I may also give information about official misconduct or police misconduct under the *Crime and Misconduct Act 2001* to the Crime and Misconduct Commission;[5] and/or information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's professions or trade if I reasonably believe the information might cause the body to inquire into, or take steps in relation to, the conduct.[6]

I indicate at this stage that I am satisfied that there is no evidence upon which I could be satisfied that any person has committed an offence so as to give rise to the provision of information by this court to either the Director of Public Prosecutions or the Chief Executive of a department as provided in s.48 (2) of the *Coroners Act 2003*; or to a disciplinary board as provided in s.48 (3) of the *Coroners Act 2003*.

I also indicate at this stage that this court is mindful that all proceedings of this kind are sad and difficult and no more so, in this case, than for Andrew's younger sister Anita and younger brother Anthony. Anita was no more than 21 years of age at the time of Andrew's death and Anthony was younger still. Their parents had both passed away by the time Andrew was twelve years of age, leaving Anita as the next of kin.

Both Anita and Anthony attended and represented themselves at the inquest proceedings at Charters Towers, and Anita has attended here in Brisbane, supported on both occasions by her partner Josh. They have each demonstrated considerable courage, resilience and skill in addressing their concerns about Andrew's death to this court and this court would hope that they would be satisfied that they have done everything possible to ensure that no other family is placed in a similar situation in the future.

I would again like to express my sympathy and condolences and those of the Court to Anita, Anthony and Josh, who have travelled great distances to attend the hearing; and I thank them for their contribution to the inquest.

I also thank Detective Senior Constable Gregory James Burns, the investigating officer, who provided the Court with a thorough police investigation report, which has greatly assisted the coronial process. That report contained numerous statements of relevant witnesses and significant additional material, including volumes of medical, hospital and other records.

As a result, the following witnesses were examined during the inquest:

1. Forensic Pathologist Professor David Williams, who undertook the autopsy and provided post-mortem and toxicology reports[7];
2. Detective Senior Constable Burns;

[4] S. 48(2) Coroners Act 2003.
[5] S. 48(3) Coroners Act 2003.
[6] S. 48(4) Coroners Act 2003.
[7] Exhibit 26

3. Janice May Anderson, Nurse Assistant at the Charters Towers Rehabilitation Unit (hereinafter referred to as the CTRU) at the time of Andrew's death;
4. Vicki Lorraine Lowe, Registered nurse, registered midwife and night shift nurse in charge at CTRU;
5. Ambulance Officer David Raymond Lowe;
6. Sergeant Ian Russell Harbour;
7. Charles Jeffery Archer, Nurse Assistant at the CTRU;
8. Deanne Lee Hellsten, Registered Nurse, and Clinical/Psychiatric Nurse at the CTRU;
9. Dr. John Allan, Director, Integrated Mental Health Services, Townsville Hospital District, who undertook an investigation into the events surrounding Andrew's death;[8]
10. Nicholas Parlichuk, Nurse Unit Manager at CTRU;
11. Alison Wyle Davamoni, Manager Integrated Mental Health Services and Acting Director of Nursing at CTRU;
12. Dr. Satish Karunakaran, Clinical Director, Charters Towers Rehabilitation Unit at the time of Andrew's death;
13. Dr. Morris Bersin, one of the treating psychiatrists at the Townsville Hospital during Andrew's various admissions to that Mental Health Unit; and
14. Anita Lather.

In addition, the court appointed an independent expert witness, Dr. William John Kingswell, Psychiatrist, who provided two written reports[9] and gave oral evidence in relation to clinical issues.

It had, at an earlier time, been proposed to call Dr. Aaron Groves, the Director of Mental Health, to give evidence in relation to systemic issues concerning the delivery of mental health services in Queensland. In light of the significant evidence, however, which he gave in Cairns at the inquests into the suicide deaths of Patrick Lusk, Charles Barlow and Emily Baggott, in relation to which findings were delivered and substantial recommendations made on 15th December 2006, I did not consider it necessary to hear further from Dr. Aaron Groves.

It is the intention that the recommendations made as a result of the evidence in this inquest be supplementary to those made as a result of the inquests referred to above.

In this matter, whilst the court sat in Charters Towers, arrangements were made for a visit to the Charters Towers Rehabilitation Unit to view the facilities, including the particular room occupied by Andrew during his admission; and the court thanks the Charters Towers Rehabilitation Unit staff for making those arrangements. I note that a number of those staff have travelled to Brisbane for the conclusion of the evidence here, when they were not otherwise required to do so. It is a measure of their concern for Andrew and his family, quite evident when they were giving their evidence as well, that they have given so freely of their time.

---

[8] Exhibit 49.
[9] Exhibits 51 and 61.

The Coronial Investigation Report of Detective Senior Constable Burns[10], the reports of Dr. Karunakaran[11], psychologist Louis K. Salzman[12], Dr. Laura Flaherty[13], Dr. Morris Bersin[14], Dr. Allan[15], and Dr. Kingswell[16] together with the significant medical records[17] and other medical evidence outline a significant history of mental health diagnoses, numerous hospital/care admissions throughout Queensland, serious and ongoing attempts of deliberate self-harm, substance addiction and abuse, multiple suicide attempts, treatment resistance, and absconding from hospital/care placements by Andrew from the time he was aged approximately 9 years of age.

Andrew also suffered from an intellectual impairment; and an hypoxic brain injury, the latter as a result of Andrew's consumption of a quantity of sheep dip, two (2) bullets and 400mg of Olanzapine, an anti-psychotic medication, in Rockhampton in July 2003.[18] He was admitted to the Rockhampton hospital as a result and thereafter he had five (5) admissions to the Townsville hospital and the final admission was to CTRU where he died.

All of the medical witnesses opined that the significant history referred to above meant that management of Andrew's care was and remained extremely difficult, complex and challenging, becoming even more so after the serious incident in July 2003.

Between the 8th October 2003 and the 24th February 2004, Andrew was a regulated patient in the Mental Health Unit at the Townsville Hospital under an involuntary treatment order pursuant to the Mental Health Act Qld 2000. During that period, Andrew spent several days in the closed four (4) bed ward of the unit, engaged in deliberate self-harm on almost a daily basis, absconded, consumed illicit substances; as a result of which several management strategies were implemented.

Community placements were attempted on four (4) separate occasions. Unfortunately, on each occasion, Andrew could not cope in the external environment and had to be readmitted to the Townsville hospital, an environment which his medical team considered was by then contributing to his chronic difficulties, such that Andrew would require several months of treatment in a rehabilitation environment.[19]

The medical team[20] therefore determined that Andrew be transferred to the Charters Towers Rehabilitation Unit, which offers a structured behavioural program in a controlled environment for learning/relearning everyday living skills so as to allow people to live in their own communities, with the prospect of being re-integrated into mainstream society. Dr. Satish Karunakaran assessed Andrew following the referral and concurred with the opinion of the Townsville treating medical team, which

---

[10] Exhibit 1 (pages 4-6).
[11] Exhibit 13.
[12] Exhibit 42.
[13] Exhibit 44.
[14] Exhibit 60.
[15] Exhibit 49
[16] Exhibit 51.
[17] Exhibits 48, 59, 62-64 inclusive.
[18] Exhibit 13.
[19] Exhibit 13 page 3 paragraph 1.
[20] Exhibit 60. Report of Dr. Bersin.

included Dr. Morris Bersin. The court accepts Dr. Bersin's evidence that Andrew did not engage in self-harming behaviour between mid-January 2004 and his transfer to CTRU on 24th February 2004, although Andrew continued to misuse alcohol and marihuana.

Andrew's case history was shared with CTRU staff before Andrew's transfer, Andrew was then transferred on 24th February 2004 and broad concensus was reached amongst the different treating professionals about the management plan to be implemented in Charters Towers.[21] As stated in the report of Dr. Satish Karunakaran[22], "the risk of serious self harm was appraised using standard protocols and the risk was well appreciated….the decision to admit to Charters Towers was made after broad consensus with the treating team at Townsville and the team at CTRU".

Once at Charters Towers Rehabilitation Unit, the progress notices indicate that whilst incidents of self-harm and threatened self-harm by Andrew occurred, they were overall reduced in frequency from those which had occurred whilst in Townsville in 2003. Dr. Karunakaran's report indicated that this decrease gave the team some optimism about the progress being made by Andrew.

In relation to such incidents as did occur, there is no evidence to suggest that all such incidents, occurring at either placement, were not documented, reviewed, assessed and actioned in accordance with protocols and management strategies that had been implemented specifically for Andrew[23].

Two incidents occurred on 4th March 2004 when Andrew showed a staff member superficial cuts on the right forearm, admitted to breaking a spoon to fashion a weapon and imitated the intended use of the weapon by raising his clasped hands above his head and bringing them down rapidly towards his abdomen. He remained somewhat distressed during that day and had to be sedated with Midazolam 10mg.

The next, and as it turns out, the last of the concerning incidents was a verbal enquiry by Andrew to Nurse Deanne Lee Hellsten early in the evening of 5th March 2004, as she was attending upon him in his room in order for him to take his medication. Nurse Hellsten knew Andrew from information from Nicholas Pachiluk about how the team was managing Andrew; and considered that Andrew was a high risk because of his significant history of self-harm, although she was unaware of any suicide attempts. (Nurse Hellsten had spent quite some time with Andrew earlier in the day and had allowed him leave to go and buy some cigarettes. There was no paperwork to contradict that Andrew had leave and there was nothing about his behaviour that indicated any reason why he should not go. Nurse Hellsten made a deal with Andrew to return within a certain time which he did and Nurse Hellsten provided Andrew with favourable feedback as a result).

Andrew's medication was stored in a locked top drawer of a number of drawers within a closet opposite his bed. Once Nurse Hellsten unlocked and opened the drawer, Andrew removed some sheets of medication and asked what would happen if he took all of the stored medication. Nurse Hellsten redirected Andrew by not

---

[21] Exhibit 13. Report of Dr. Karunakaran.
[22] Exhibit 13.
[23] Exhibit 46.

answering his specific question but instead asked him what medication he was ordered to take then; Andrew responded correctly, replaced the sheets of medication and took the necessary medication. Nurse Hellsten then closed and locked the drawer, checked that it was secure and left the room.

The medical evidence of Drs. Karunakaran, [24]Dr. Bersin and Dr. Kingswell all support Nurse Hellsten's response as an appropriate one under the circumstances of Andrew's particular mental health history and placement.

Nurse Hellsten later spoke briefly to Andrew in the corridor at approximately 21.30 that evening, before he went to bed; and was in fact the last person to speak to him. She then handed over to Registered Nurse Lorraine Lowe at approximately 21.45 hours. No formal notes were or are kept of what is said at handover, although Nurse Lowe recalls being told by someone about Andrew's medication enquiry. Nurse Lowe, is however, not trained in mental health issues, did not do a risk assessment, did not have access to any risk assessment and was not a key worker for Andrew. The handover to Nurse Lowe was completed at approximately 22.15.

No risk assessment form was ever in fact completed for Andrew at CTRU, as when attempts were made upon admission, he put a cigarette lighter to it. There is no evidence of any other risk assessment document, except a plan by Dr. Satish notated in the Inpatient Progress notes for CTRU on 2/3/04.[25]

Certain checks were made on Andrew throughout the night of 5th March 2004 by Enrolled Nurse Joe Moxham and Janice Anderson. The only checks actually noted in the chart, however, were the check by Janice Anderson at 22.30 that night and the check by both Nurse Anderson and Joe Moxham at 05.00am the next morning, the 6th March 2004. Other checks by Joe Moxham throughout the night were random and as exception reporting is the practice, no notes were made in relation to those checks.

Ms. Anderson stated that the process adopted in checking on Andrew at 5.00am, was that they both went together to the door, knocked on the door, waited for an answer, went in anyway without one and, without turning the lights on (as Joe carried a torch which he shone on the chest or stomach area), checked that he was breathing. It is routine practice that checks are done without disturbing patients. Nurses Anderson and Moxham also made sure that all the windows were closed, flashed the torch around the room, confirmed with each other that everything was okay and left.

Neither of them or any of the nursing staff on the night shift heard any noises from the deceased's room overnight or observed any damage to any items within the deceased's room overnight.

There is no evidence, however, of any check being undertaken on 6th March 2004 between 5.00am and 7.00am – 7.15am (when patients are usually woken for breakfast) and no evidence as to why no check was done between those times. Both Janice Anderson and Joe Moxham handed over to the next shift at 5.40am and went home at 6.00am.

---

[24] Exhibit 13
[25] Exhibit 45.

At 7.15am on 6th March 2004, Charles Jeffrey Archer entered Andrew's room to wake him for breakfast and located him lying on his bed displaying no vital signs of life. Mr. Archer attempted to wake him, received no response and immediately sought assistance from Enrolled Nurse Helen Anne Louise Olsen. Nurse Olsen called Nurse Hellsten, who called Registered Nurse Deborah Jane Warters. When Nurse Olsen entered the room, she noticed that the locked top drawer "did not look right" so she grabbed the handle, as a result of which the face of the drawer fell to the floor.

RN Warters then called the Ambulance, the On Call Nursing Unit Manager Nick Pavlichuck and the Police, as well as treating doctors, including Dr. Satish Karunakaran.

The first response Police Officers Sergeant Ian Russell Harbour and Constable Wayne Lester Rickerby, upon entering Andrew's room, observed a drawer cover upon the floor to the right of Andrew's bed and near an open inbuilt wardrobe, the top drawer of which was missing the outer cover. There was a lock on the drawer cover located upon the floor, which lock was found to still be engaged in the lock position without any signs of the lock having been tampered with[26].

I accept that the drawer cover had been physically forced from its original position as demonstrated in photos taken by police,[27] and fingerprint evidence. [28]The drawer was made of chipboard, described and observed by Detective Senior Constable Burns as "flimsy"[29].

There was no evidence of any other disturbance, or interference or trauma to either Andrew or anything within the room, excepting for items upon the body of the deceased which related to the medical assistance rendered by Ambulance personnel. None of these items were suspicious in nature. There were no signs of any struggle or unlawful activity having occurred within the room of the deceased. No note or like document was located in the form of a suicide note. There were in fact no suspicious circumstances.

What is concerning, however, is the evidence[30] that located in the open drawer was a quantity of empty boxes of medication, including one (1) box Seroquel 200mg; one (1) box Quetiapine 200mg; one (1) box Zoloft 50mg; two (2) boxes Patoprazole 40mg and two (2) boxes Mirtazapine 30mg. Dates on these empty boxes were noted to range from 24th February 2006 to 5th March 2004. The report of the investigating officer states that "….there were 201 empty single dose medications within the drawer in the room …….which…would allow for approximately 150 tablets having been taken orally by the deceased, taking into account his daily prescribed medications, reducing the original total of 201 tablets. The blister packs of these respective medications had their seals broken, and medication previously contained within was now unaccounted for".[31]

---

[26] Exhibit 46. Report of Detective Senior Constable Burns.
[27] Exhibit 50.
[28] Evidence of Sergeant Paul James Molloy.
[29] Exhibits 46, 47 and photos in Exhibit 50.
[30] Exhibit 46.
[31] Exhibit 46.

In relation to the medication, and having regard to the report of the investigating officer, it would appear that Andrew had stored in the medication drawer beside his bed prescribed medication in excess of that prescribed to him for a one week period and indeed for approximately at least a 14 day period.

Whilst there is no evidence that the particular drawer/cupboard unit had been tested to take into account the possibility that patients with a self-harming history or any patients at all would be able to physically gain access to the locked drawer containing medications, there is also no evidence of any patient within the rehabilitation unit having ever previously attempted, successfully or otherwise, to break into the drawer.

After the death, an autopsy was conducted by Senior Specialist Pathologist David John Williams[32]who concluded that the cause of Andrew's death was aspiration of gastric contents due to, or as a consequence of drug toxicity. In relation to the time of death, Professor Williams' evidence was that it was not possible from his perspective to be precise about that, such that no particular time between 9.30pm and 7.15am can be stated with any certainty.

Also following Andrew's death, Dr. John Allan undertook a sentinel event review, prepared an action plan and made recommendations[33]. Management team recommendations for the CTRU made by Dr. Allan and implemented were as follows:

1. Amounts of medication kept in the cabinet in individual consumers' rooms were reduced to seven days supply only.
2. CTRU policy was altered to ensure that consumers who are measured to be medium risk and above to suicide would have their medications moved to the Clinic Room and administered from there until they were fully assessed as no longer being at that level of risk. Education of consumers about self-medication would continue according to each consumer's abilities and capacity.
3. The format and sturdiness of the cabinet drawer and lock system was reviewed and improved.
4. The Self Administration Medical Plan, allowing for consumers to self-medicate was also reviewed.

Dr. Kingswell, the court-appointed expert specialist psychiatrist has considered all of the clinical issues surrounding Andrew's treatment and the circumstances of his death. Whilst he stated in his report [34] that he had some minor criticisms of the assessment and management process at the Townsville hospital, they were limited to; the practice whereby Andrew was asked to guarantee his own safety (and on one occasion signing an agreement to that effect) and the delay in performing the brain scan which was ordered by Dr. Karunakaran, which Dr. Kingswell considered may have provided further information.

There is evidence that the RANZCP Guidelines for treatment of Schizophrenia and related psychosis, as referred to by Dr. Kingswell, were not published until August 2004, a period of some five (5) months after Andrew's death.

---

[32] Exhibit 26.
[33] Exhibit 49 and attachments.
[34] Exhibit 51 at page 5.

Dr. Kingswell in fact opined that the management and treatment of Andrew's illness was, on the whole, managed well, including the update of risk assessments at critical points [35] and changes to medication.

In relation to the issue of the storage and distribution of medication to patients, Dr. Kingswell set out a number of persuasive reasons why patients should manage their own medications. As he stated, "...most with schizophrenia and other mental illnesses are perfectly capable of doing so" and "……Where else can clinicians test a person's commitment and capacity to manage and comply with medications?"[36] These views support those of Dr. Karunakaran.[37]

In relation to the issue of Andrew's transfer from an acute mental health unit in Townsville to an unsecured facility in Charters Towers, Dr. Kingswell's medical opinion is that, against the significant history and the knowledge of the risk, "it was questionable whether it could have been perfectly managed in any setting."[38] Given the decision to manage Andrew by continuing his medication, observing him visually, providing supportive staff, and securing medications in a locked drawer, Dr. Kingswell is not critical of that plan. Dr. Kingswell indeed indicated that, having regard to the significant suicide attempt in Rockhampton in 2003, Andrew's illness may never have been able to have been adequately controlled thereafter, despite good standards of care and the best efforts of medical staff.

In relation to the issues raised by the investigating officer about the placement of CCTV monitoring in mental health facilities, Dr. Kingswell's opinion, which the court accepts, is that patients do not like the intrusion; human contact is diminished; the system is only as the good as the person monitoring and effective observation is thereby reduced.

Dr. Kingswell was concerned, however, about the communication between care facilities themselves (Andrew had admissions to at least 9 different facilities in Queensland) and communication between those various care facilities and Andrew's family, about the level of risk faced by Andrew as a result of his illness.

It was clear from Anita Lather's evidence that she was unaware of Andrew's significant mental health history; was not involved in discussions with medical staff at any of Andrew's care placements in relation to that history, the various management strategies, the attempts at community placements, Andrew's placement in the "closed" ward in Townsville or the decision to transfer Andrew to Charters Towers.

Of great concern is that this occurred despite the fact that Anita was known to be the next of kin; that correspondence had been forwarded to her when Andrew was in the Townsville hospital, notifying her that Andrew was under an involuntary treatment order; and that she had in fact been chosen or declared, by written notation in the Townsville hospital file on 12th December 2003, to be Andrew's allied person

[35] Exhibit 51 at page 4.
[36] Exhibit 51 at page 5.
[37] Exhibit 13.
[38] Exhibit 51 at page 6.

pursuant to the provisions of the Mental Health Act 2000.[39] Indeed, the first time that Anita became aware that she was named as Andrew's allied person was at the conclusion of the evidence during this inquest.

Pursuant to s.340 of the Mental Health Act QLD 2000, the function of an involuntary patient's allied person is to help the patient to represent the patient's views, wishes and interests relating to the patient's assessment, detention and treatment under the Act. There can be no doubt that Anita was capable, readily available and willing to be Andrew's allied person as required of an allied person and she came therefore within s.341 of the Mental Health Act QLD 2000.

Anita's evidence is that, on at least one occasion prior to Andrew's transfer from Townsville to Charters Towers, he expressed a wish to her that he not be transferred to Charters Towers. Whilst the evidence supports the view that the decision to transfer Andrew to Charters Towers was a sound one, under the circumstances, Anita will nonetheless be feeling that she could at least have expressed Andrew's concerns and obtained information which would have decreased both her concerns and Andrew's concerns.

Anita also experienced some difficulty in gaining access to the clinicians following Andrew's death. Anita indicated that initially she was very upset and did not take up an opportunity to discuss the issues, but ideally there should be some formal process, taking into account that families need time to grieve, but also time in which to understand how their loss has come to be.

To their credit, Drs. Bersin and Karunakaran did accept that communication with Andrew's family could have been better. On the basis that Anita gave her evidence after the bulk of the other witnesses, all of whom gave their evidence in Charters Towers, those witnesses did not have the same opportunity to comment on this issue.

CORONIAL FINDINGS
I make the following findings:-

1. The deceased is Andrew David Lather born on 20th October 1979 and 24 years of age at the time of death.
2. The time of death is at an unknown time between 9.30pm on 5th March 2004 and 7.15am on 6th March 2004.
3. The place of death is Room 10, Charters Towers Rehabilitation Unit 35 Gladstone Road, Charters Towers, Queensland.
4. The cause of death is aspiration of gastric contents due to, or as a consequence of drug toxicity following the ingestion by Andrew of a large quantity of varied medication.

RECOMMENDATIONS

Pursuant to s.46 of the Coroners Act 2003, I make the following recommendations;-

[39] Section 339 Mental Health Act 2000.

1. That the Queensland Health Patient Safety Centre produces and introduces electronic standardized risk assessment documents to be used throughout the mental health system; that such standardised risk assessment documents be sufficiently comprehensive and prescriptive to ensure that all relevant information is collected on the initial admission of each mental health consumer; and that forcing functions be included to ensure that key areas of information are not neglected.

2. That Queensland Health provides standardised training programs in relation to such risk assessment documents; and that competency-based assessment of all Queensland Health staff undertaking such assessment, whether full-time, part-time or casual, is conducted on a regular basis.

3. That Queensland Health standardises the assessment and management of consumers with Schizophrenia and related psychoses within all Queensland Health Mental Health facilities; and that in the interim, Queensland Health ensure the dissemination of, and training in the use of the Royal Australian and New Zealand College of Psychiatrists Clinical Practice guidelines for the treatment of schizophrenia and related disorders.

4. That the Mental Health Branch of Queensland Health support the formation of a multi-disciplinary committee, comprising pharmaceutical and nursing personnel to develop a State-wide policy for the safe management of patient dispensed medicines in Community Care Units, Extended Treatment Units and Rehabilitation Units; and that such a committee give consideration to the following issues:
    (a) Whether prescribed medications should only be housed outside of consumer's rooms in a non-access area and only administered from such an area by trained staff; or whether there are categories of consumers, for example, "low risk" consumers who could be permitted to have their medication stored in their room, albeit in a suitably credentialed storage facility, capable of external locking and withstanding deliberate human interaction by physical force;
    (b) Whether prescribed medications should only be housed in consumer's rooms in a limited supply, for example, no more than seven (7) days supply;
    (c) That the standard and quality of storage facilities in such Units, whether in central areas or within consumer's rooms be reviewed.

5. That Queensland Health develops, disseminates and provides training to all staff so as to give effect to ceasing the practice by which consumers with mental health issues are requested to guarantee their own safety.

6. That Queensland Health develop policies, procedures and training programs to ensure that medical records of all observations of consumers in mental health facilities by health staff, whether active observations or observations of sleep patterns, accurately reflect the specific time of the particular observation; a comment as to the particular observation; the name of the person making the observation; and that the record be signed by the observer.

7. That Queensland Health accelerate the implementation of a state-wide electronic network of patient information that allows treating health professionals, including both inpatient and community staff, to rapidly access patient data throughout the State; and that Queensland Health provide the necessary funding as a matter of priority.

8. That Queensland Health reviews the provisions of the Health Services Act 1991 Qld as they relate to the disclosure of confidential information and implement such changes as will remove any doubt that the confidentiality of information relating to a person receiving a health service is balanced with the duty of care to that person, the rights of the public to protection against the risk of harm, the rights of carers and support networks to meet their responsibilities to the person and other members of the household.

9. That Queensland Health develops, implements and provides training in state-wide guidelines defining the issues of confidentiality of mental health as they affect clients and their families and making clear to all mental health workers the circumstances in which it is appropriate for mental health staff to share information regarding the person.

10. That the Queensland Government increase funding to a range of community-based services to assist persons with mental health problems, particularly in regional, rural and remote areas; and including both clinical and non-clinical services, generic and mental health-specific services.

11. That Queensland Health develops policies and procedures to ensure that carers are actively engaged by mental health staff in treatment decisions and referral decisions; provided with information about their rights and responsibilities; provided with information about available mental health services/disorders/problems and available treatments/support services; and information about all outcomes; and that such engagement and information occurs/is provided as soon as possible after a consumer enters a mental health service, and as soon as possible after any negative outcome, with a view to maximising the role and involvement of carers in the mental health system.

12. That Queensland Health develops and implements policies; and provides competence-based training against those policies; to ensure that, upon transfer of any consumer between treatment/care facilities, there is also transferred a referral package for the particular consumer; to include information as to areas of risk, the most recent risk assessment, the proposed treatment plan, previous and suggested behaviour management, previous community placements and outcomes, the consumer's wishes and the views of any allied person for the consumer, in relation to the transfer.

13. That Queensland Health develops and implements policies by which notification is made to allied persons for consumers under involuntary treatment orders, of their status as such; the provision to such persons of information as to their rights and responsibilities; and the active engagement

with allied persons in relation to the relevant issues as they affect the responsibilities of the allied persons.

I direct that copies of these findings and recommendations be provided to the following:-

1. The Minister for Queensland Health.
2. The Director-General of the Department of Health.
3. The Director of Mental Health, Dr. Aaron Groves.
4. The State Coroner, Mr. Michael Barnes.
5. Dr. William Kingswell, psychiatrist.
6. The Manager, Charters Towers Rehabilitation Unit.
7. Dr. John Allan.
8. Dr. Morris Bersin.
9. Dr. Satish Karunakaran.
10. Anita and Anthony Lather.
11. Mr. John Tate, Counsel, Crown Law, Brisbane.
12. Mr. Kevin Parrott, Counsel, Crown Law, Brisbane.
13. Mr. Gavin Rebetzke, Solicitor, Roberts and Kane, Solicitors, Brisbane.

TINA PREVITERA
CORONER
BRISBANE
2nd March 2007.